

Palliative care

INTEGRATING PSYCHOSOCIAL RESOURCES AND PALLIATIVE CARE

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SUMMARY: Interdisciplinary teams

Feldstain A, Bultz B, Sinnarajah A, et al. A Growing Collaboration between Psychosocial Oncology and Palliative Care. 2017 CAPO Conference, Vancouver, BC.

The World Health Organization's (WHO) 2007 guide for effective palliative care in cancer identified that palliative care services should be integrated into the existing health-care system and strategically linked to treatment services.¹ In cancer centres, this can be accomplished by closely integrating psychosocial resources and palliative care. It has been theorized that such an interdisciplinary approach is especially beneficial for patients with advanced cancer, who often suffer from high symptom burden and psychosocial distress. This pilot study evaluated implementation of WHO recommendations in the Tom Baker Cancer Centre Departments of Psychosocial and Rehabilitation Oncology and Complex Cancer Management Service (CCMS), which is an outpatient palliative care consultation service. The researchers employed patient self-reported distress using the Screening for Distress checklist² as an indicator of the effectiveness of this integrated collaboration.

The interdisciplinary team saw a total of 117 patients in January, April, July and October 2017. Patients remained in the team's care for an average of 4.7 months, and 70% had a stage IV diagnosis with varied tumour sites. From baseline to completion of consultations, patients in the highest distress categories reported a significant decrease in pain, fatigue, depression and anxiety, and an increase in wellbeing. Patients who had moderate levels of these symp-

IN BRIEF

Already known

- The World Health Organization recommends integrating palliative care with treatment services in health systems.

What this study showed

- Integrating psychosocial resources and palliative care in one cancer centre enabled significant decreases in pain, fatigue and depression in patients with the highest distress at baseline. Patients starting with low distress saw it worsen over time despite integrated resources, likely due to advancing disease.

Next steps

- Better understand the causes of high distress to direct integrated resources to those who will benefit most.

toms were able to maintain moderate scores at completion. Those with low baseline scores in pain, fatigue and overall wellbeing saw a significant increase in pain and fatigue between the first and last consultation, however this was not observed in patients who had low depression and anxiety scores at baseline. The worsening of pain and fatigue over time was somewhat expected due to the advanced stage of these patients' cancers.

LANDMARKS

Looking at particular sources of distress, researchers found a decrease, between first and last consultation, in patient-reported distress related to sleep, fear, weight, frustration/anger, being a burden to others, and sensitivity to cold. However, even at the time of discharge these symptoms were reported by between 14% and 34% of patients.

COMMENTARY: Based on these results, it seems plausible that interdisciplinary collaboration between psychosocial rehabilitation and palliative care has the potential to reduce symptom burden and distress for patients with advanced cancer. Better communication, cooperation and understanding between physicians, nurses, pharmacists and psychologists may lead to a greater number of referrals to appropriate resources, and less likelihood that symptoms slip through the cracks. In addition, integration of the healthcare team may result in higher patient satisfaction with care.

Given the potential benefits to patient wellbeing, integrated models of care warrant further exploration. Studies

This could be explained by advancing disease, lack of recognition from clinicians, poor communication between patients and healthcare providers, or inadequate referral to appropriate resources (i.e. sleep clinics). It may also indicate a need for further, likely qualitative, research with patients to determine the root causes of elevated symptoms.

comparing integrated models to control groups or historical data on distress would help determine the specific advantages of collaboration. Qualitative research into sources of distress and resource use could improve our understanding of patients with high symptom burden and help to direct resource allocation for integrated programs.

References:

1. World Health Organization. (2007). WHO guide for effective programmes:
2. Palliative care [pdf document]. Retrieved from: http://apps.who.int/iris/bitstream/10665/44024/1/92415_47345_eng.pdf
3. Bultz BD, Groff SL, Fitch M, Blais MC, et al. (2011). Implementing screening for distress, the 6th vital sign: a Canadian strategy for changing practice. *PsychoOncology*. 20(5):463-9. doi: 10.1002/pon.1932